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Letter to the Editor

Schizophrenia and COVID-19 delirium



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ABSTRACT

Since its outbreak, coronavirus disease 2019 has been producing atypical manifestations aside from fever, coughing and dyspnea. One of the most common is delirium, which, however, is highly overlooked. This has consequences in the treatment of patients and also may lead to underdiagnosing the infection. In this work, we present the case of a man diagnosed with schizophrenia, who had been stable for more than 20 years and that presented with an atypical picture of psychotic and confusional symptoms related to COVID-19 infection.

To the editor

Coronavirus Disease 19 (COVID-19) was declared a pandemic by the World Health Organization (WHO) in March 2020. Since the outbreak, atypical presentations such as delirium, confusion and stupor have been developing (Alkeridy et al., 2020). Delirium has been found highly common in hospitalized patients, due to factors related to this virus directly affecting CNS. Delirium is considered a marker of encephalopathy and worse prognosis (Kotfis et al., 2020) and its prevention and recognition may help to identify underlying infection in otherwise asymptomatic patients (Alkeridy et al., 2020).

COVID-19 has already had a great impact in the general population worldwide and patients diagnosed with schizophrenia are at greater risk of infection and its consequences, due to difficulties following preventive rules and the presence of other medical comorbidities. Moreover, infected patients with schizophrenia may have more severe symptoms compared to others. These patients also may be impeded their access to treatment and intervention, rising the risk of relapse (Fonseca et al., 2020). Despite this conditions, patients with severe mental disorders have widely been overlooked (Li and Zhang, 2020).

We present Mr. S., a 65 year-old diagnosed with stable schizophrenia for more than 20 years, treated with amisulpride 200 mg per day until august 2019, when he discontinued it voluntarily. He suffers hypertension and sleep apnea syndrome treated with CPAP.

On March 27th, 2020, Mr. S. was admitted to the psychiatric inpatients unit due to bizarre behavior, perplexity, incoherent speech that had been occurring for 20 days approximately. His spouse explained that he would be angry because somebody had insulted him and would wander naked at home. She reckoned the situation was triggered by the alarm estate and confinement in Spain, that had started on March 14th. At first, Mr. S. was agitated, aggressive, confused and disoriented in time and did not consent to take oral medication – amisulpride. He presented with global insomnia, disorganized behavior and discourse, echolalia. He also started to show some loss in basic skills, such as feeding himself and getting dressed. Some amnesic fails were observed though they soon recovered. Amisulpride was augmented to maximum dosage to 2400 mg per day. On April 5th, he was tested for COVID-19 following the novel hospital protocol. PCR resulted negative.

Suspecting organic conditions underlying and the scarce response to treatment, we requested a cephalic CT scan – patched hypodensities in

deep white matter suggestive of leukoencephalopathy of small vessels – and a cerebral MRI – dilatation of ventricular system and subarachnoid spaces according to patient's age. By May, we suspected a confusional syndrome in the context of the COVID-19 pandemic and antibodies were requested, with positive results for both IgG and IgM. A PCR was then carried out, resulting negative. Afterwards, melatonin up to 7 mg per day and haloperidol at low doses (2 mg per day) were added. Amisulpride was adjusted to 600 mg per day.

Currently, Mr. S. has normalized speech and behavior and has regained basic autonomous abilities and temporal orientation. Improvement is slow but steady.

Delirium is known to be common in patients infected with COVID-19. However, it remains overlooked and it is not yet included in guidance for diagnosis, which would have great impact for patients and would lead to underdetection of coronavirus disease. On top on that, patients with schizophrenia are usually overlooked though that disorder may represent a greater risk of medical comorbidities and increased risk of COVID-19 infection, even when hospitalized. Additionally, viral exposure, medical treatment for the coronavirus infection and psychosocial distress have been associated with psychosis (Brown et al., 2020).

In our case, it is difficult to determine whether Mr. S. acquired coronavirus disease prior admission or during hospitalization. He did not present with organic symptoms such as fever, coughing or similar. What seems feasible is that a mild psychotic relapse has been worsened by this infection, producing confusional symptomatology as an atypical presentation. Furthermore, we wonder that even if it is a mild infection as it did not require intensive care medicine, its severity lies on the basal psychiatric condition.

Awareness for non-specific symptoms is granted, especially in vulnerable groups, where clinical management can be challenging (Brown et al., 2020). Not only are medical aspects of this virus important, but also research on the psychiatric factors should be warranted, as it is well known that this virus is highly neurotropic and psychiatric patients, a population at risk. Hence, clinicians and families must keep alert on both physical and psychiatric symptoms, in order to detect the infection in early stages (Fonseca et al., 2020).

Declaration of Competing Interest

None.

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